ICD Operations Plan Outline – Model 2 HN

	Model 2 (HN)
Health Neighborhood Assistance with Formation	*How will the Departments support formation of HNs?* • *Facilitation of relationships by contractor* • *Distribution of template care coordination agreements* • *Distribution of anti-trust guidelines* • *Use of central website hub/portal for communications with Departments and peers* • *Drill down and distribution of data points: geographic incidence of MMEs by population group, cluster analysis*
Health Neighborhood Administrative Structure	*Should we require co-Lead Agencies (medical and BH)?* *What are the requisites for Leads?* • *Provider type?* • *Content expertise (e.g. experience with MME populations, medical/BH care coordination, capacity to address barriers that inhibit access to care, cultural competency, disability competency, competency in person-centeredness/ dignity of risk)* • *Staffing/credentials* • *Solvency* • *Generative/connective capability (e.g. experience in connecting providers across disciplines/networking, experience in connecting MMEs with other providers)* *Should any entities have preferred status as Leads? On what basis? E.g.* • *Large primary care practices* • *Fiscal intermediaries* • *Community-based organizations* *Should we <u>exclude</u> any entities from serving as Leads?* • *DMHAS LMHAs?* • *Hospitals?* • *Nursing homes?* *Will we require HNs to have a governing or advisory body? If so:* • *Should we indicate requirements for composition (e.g. providers, consumers)?* • *Should we indicate requirements for participatory decision-making concerning operation of HN?*
Health Neighborhood	*What are the key duties of the Leads? If there are co-Leads, how will duties be allocated as between medical and BH Leads?*

Roles of Lead Agencies	1) *Administrative functions:* • *infrastructure: operating capital, management, information technology* • *contracting* • *management/oversight of care coordination provided by the network* • *compliance with Department requirements* • *support for provider members: data sharing, use of evidence-based protocols, CQI* • *performance reporting* • *accountability for provider standards (including termination of non-performing)* 2) *Fiduciary functions: distribution of APM II, performance payments* 3) *Content expertise/direct service* *Will there be any limitations on the role of Leads?* • *Will Leads be conflicted from offering care coordination, direct FFS and/or supplemental services under the Demonstration?* • *Will Leads be bound by existing protocols (e.g. MFP)?* *Are Leads permitted to sub-contract out for any of these functions? If so, under what circumstances?*
Health Neighborhood Provider Composition	*What is the minimum <u>required</u> set of medical, BH and LTSS providers? What is the required incidence of required providers relative to the number of participating MMEs?* • *Primary care physicians (must define PCP: e.g. independent practitioners, FQHCs, clinics) /PCMH practices* • *Specialists: list required (e.g. cardiologists, nephrologists, etc.)* • *Behavioral health providers: list required (e.g. psychiatrists, psychologists, etc.)* • *LTSS providers: list required (e.g. homemaker-companion, adult day care)* • *Home health agencies* • *Hospitals* • *Nursing facilities* • *Hospice providers* • *Pharmacists (must indicate the nature of the participation: are we enrolling individual pharmacists or pharmacies?)* • *Dentists?* • *Transportation providers?* *Will we <u>require</u> participation of any other <u>types</u> of providers? E.g.:* • *Information & assistance/ADRC* • *Contractors for supplemental services (e.g. pharmacists trained in medication therapy management [MTM] strategies, nutritionists/registered dieticians)*

	Will we <u>require</u> participation of any <u>specific</u> providers? E.g.: • *Contractors for supplemental services (e.g. UConn School of Pharmacy MTM providers, Yale School of Public Health trained falls prevention providers, etc.)* • *Agencies on Aging* • *Centers for Independent Living* • *LMHAs* • *Administration on Aging-funded chronic disease initiatives* • *Other?* *Will we indicate that participation other types of provider is, although not mandatory, <u>preferable</u>?* • *Housing providers* • *Volunteer programs (e.g. friendly visiting)* • *Bill payment/tax preparation assistance* *What are the credentials/requisites for provider participation?* • *Medicaid performing provider in good standing* • *Licensure/certification in good standing* • *Good financial standing (define) and no bankruptcy filing* • *Etc.?* • *Can non-Medicaid providers (e.g. I&A, housing organizations) participate?* *Will the Lead be responsible for identifying and compiling the list of all Lead Care Managers for consumers? What qualifications and training will we require for Lead Care Managers? Can all providers that have appropriately credentialed staff offer ICM?* *Will the Lead be responsible for identifying and compiling the list of all providers of supplemental services?*
Health Neighborhood Financing Model	*HNs will receive advance payments for start-up. Will these be allocated directly to the Leads? What are permissible uses for these funds?* *Will Leads receive an administrative/overhead fee? From what source (e.g. withhold from APM II payments)?* *How will we make the APM II payments (e.g. to the Leads v. directly to providers that offer ICM)? If we make the payments to Leads, how prescriptive will we be about how the payments are distributed within the HN? Will these requirements/guidelines be uniform across all HNs?* *What are the rules of participation as between other shared savings initiatives (e.g. ASOs)? Can HN participating providers also participate in an ACO?* *How will we make the performance payments (e.g. to the Leads v. directly to*

	providers)? With respect to the Performance Payment Pool (Year 1): • *What measures will we use to evaluate eligibility for performance payments?* • *What level/benchmark of achievement on these measures will qualify for a performance payment? Will there be a minimum level of achievement required for each measure, or will measurement be cumulative? How will payments be allocated as between current year achievement and improvement over time?* *With respect to the Quality Bonus Pool and Value Incentive Pool (Years 2 & 3):* • *What proportion of resources will be allocated to each?* • *Will we continue to use the same quality measures and means of qualifying for payments?* • *By what method will shared savings payments be calculated (need much more detail here)?*
Enrollment and Associated Rights	*What follows immediately below regarding passive enrollment generally parallels the ACO Rule method of attribution. Are we comfortable with using this method?* MMEs who have received their primary care or behavioral health care from an HN participating provider within the twelve months preceding implementation of the Demonstration will be passively enrolled with that HN under Model 2. The Department proposes to use a "step-wise" enrollment process under which the ASOs will: • first consider whether the individual has received care from a primary care provider (including a primary care physician, FQHC, clinic, or geriatrician <- *is this a complete set of what we mean by primary care provider?),* and if so, enroll on that basis; • if not, next consider whether the individual has received care from a behavioral health care provider (including psychiatrist, psychologist or licensed clinical social worker <- *is this a complete set of what we mean by behavioral health care provider?),* and if so, enroll on that basis; and • if not, next consider whether the individual has received care from a specialist (including, but not limited to, a cardiologist or a nephrologist <- *should we identify a specific list of specialists or consider this on a more individualized basis?*) for one or more chronic conditions, and if so, enroll on that basis. *Will there be an active process to try to affiliate individuals who are geographically proximate to an HN by have no usual and customary source of primary care? Which entity will be responsible for this? The ASOs?* *Will we continue to enroll new participants in HNs over time? Or will this be limited in time (e.g. to the first quarter of operation)?* The ASOs will over the first six months of the Demonstration provide quarterly rosters of enrollees to the HNs. Further, the ASOs will establish protocols for situations in which individuals are moving from one primary care or behavioral health care

provider to another (e.g. situations in which the Money Follows the Person project is assisting an MME in transitioning from a nursing facility to the community). *What if a beneficiary moves during the period of the Demonstration? Can s/he affiliate with a participating PCP in another HN at a later point?*

MME participants of Model 2 will receive notice and a welcome packet from a neutral enrollment broker that they have been passively enrolled in an HN. The notice will disclose:

- the benefits of participation, including, but not limited to access to the supplemental benefits that will be offered by HNs;
- the nature of information sharing that will occur;
- the nature of any shared savings agreement in which the HN is participating; and
- the right to opt out of participation in the HN.

The welcome packet will include such information as a list of provider membership in the HN, a list of qualified Lead Care Managers, and a description of how to access the supplemental benefits that will offered. Further, the welcome packet will include a form asking the MME to identify his or her preferred Lead Care Manager. The MME will be asked to return this form to the neutral enrollment broker, which will follow up with the MME at specified intervals should the MME not respond. *<- in light of CMS State Medicaid Director letter, must indicate multiple means of contact and frequency of same*

Must add material here to indicate how and at what intervals the enrollment broker will forward confirmation of enrollments and identified Lead Care Managers

The Department will also partner with other recognized and trusted sources of information & assistance to educate participants on the benefits and obligations of Model 2. Examples of these include CHOICES (Connecticut's State Health Information Program), the Aging and Disability Resource Centers (ADRCs) and Infoline.
MME participants of Model 2 retain the right to opt out of participation in an HN in which they have been passively enrolled. If an MME chooses to opt out, he or she reverts to participation under Model 1. *<-must indicate the means by which a beneficiary will be informed of the implications of this decision, and of participation in Model 1*

If MME participants of Model 2 wish to opt out of information sharing for purposes of the Demonstration, he or she reverts to participation under Model 1. *<-must indicate the means by which a beneficiary will be informed of the implications of this decision, and of participation in Model 1*

Are all beneficiaries who participate in an HN required to identify a Lead Care Manager? If an individual does not identify a Lead Care Manager, will there be a process by which he or she is assigned to one?

MME participants of Model 2 retain free choice of provider, regardless of whether a

	provider from which the MME wishes to receive service is participating in the HN.
ICM/Care Coordination	As described above, MMEs who are enrolled in an HN will be informed of the right to and will have the opportunity to select a Lead Care Manager of choice from among the network of participating HN providers. This Lead Care Manager will serve as the single point of contact for that beneficiary. *Will we require HN Lead Care Managers to conduct an initial assessment of all HN participants? Or, as indicated below, limit assessment to those who stratify at highest levels of need through predictive modeling?* Under Model 2, the HN Lead Agencies will receive monthly reports from the ASOs identifying MMEs who have been determined through predictive modeling to be high risk and in need of ICM. *<- must add detail on predictive modeling method (e.g. criteria for stratification, levels of need* The Lead Agencies will be responsible for directing these reports to the appropriate Lead Care Managers. All MMEs who are identified as in need of ICM, either through the predictive modeling approach described above or through self or provider referral, will be *contacted <- must indicate time frame for and protocol for initial contact and follow-up* by their identified Lead Care Managers to determine whether the MME wishes to participate in ICM. If the MME agrees, the Lead Care Manager will: 1) conduct a comprehensive, in-person, home-based assessment of the MME's needs and preferences with the MME and his/her preferred representatives using an electronic care plan instrument and communication tools specifically adapted for this purpose *<- must determine whether to require use of a standard assessment (e.g. ASO assessment tool), or to give HNs the latitude to design their own based on an identified set of domains and data points; must determine where the completed assessment is housed and by whom; must determine the means by which other providers can access the care plan*; 2) identify any existing sources of care coordination (e.g. Medicaid HCBS waiver care coordinator, behavioral health care coordinator, Community Living Arrangement care coordination for individuals with intellectual disabilities, Money Follows the Person transition coordinators, dental ASO care coordinators, PCMH care coordinators) *<- must identify how the Lead Care Manager interacts with other sources of care coordination*; 3) prepare and request the MME's review and approval of a care plan; 4) convene any and all relevant HN providers (including sources of care coordination) and sources of informal support (e.g. family caregivers, volunteers) in a multi-disciplinary, team-based approach to implementing the care plan, *including potential use of the HN supplemental services*; and *5) in partnership with the MME implement the care plan <- must expand to include detail on many aspects of ongoing care coordination, including, but not limited to: the frequency and nature of contacts with the MME, the frequency with which the care plan is updated, requirements for chronic disease self-management education, requirements for use of supplemental services, role of Lead Care Manager in transitions between care settings*

	MMEs who are not identified as in need of ICM through predictive modeling may self-refer for this service, and/or may identify the need for assistance from their Lead Care Manager with care coordination activities including, but not limited to, referrals to medical, behavioral health, long-term services and supports and/or community-based services.
Provision of Services/ Strategies for Integration of Services and Supports	Under Model 2, MMEs will continue to have access to the full range of Medicaid fee-for-service funded services and supports, including, but not limited to, medical, behavioral health, therapies, pharmacy, dental, transportation, and durable medical equipment. Further, MMEs will remain affiliated with any Medicare Part D plan in which they have enrolled. Model 2 will include PCMH-participating primary care practices, which have obtained NCQA medical home recognition. Features of PCMH practices that will support the goals of the Demonstration concerning care outcomes and address access barriers that have historically resulted in unnecessary use by MMEs of the ED include enhanced office hours, non face-to-face means of connecting with patients, practice-based medical care coordination, and use of electronic health records. PCMH and other practices will receive learning collaborative training in topics including, but not limited to: • applied practice of person-centeredness; • disability culture; • strategies for engaging with individuals with SMI and intellectual disabilities; and • connecting with the range of non-medical services and supports. Additionally, Model 2 will feature a number of supplemental services. Each HN will be required to identify the means through which it will offer the following to MMEs: - chronic illness self-management education - fall prevention - nutrition counseling - medication management services. - other services to be determined, potentially including peer support and recovery assistant services The ASOs will support the HNs in achieving goals related to integration of Medicare and Medicaid services and supports: *1)* The ASOs will enable HN providers to access portals through which providers can view utilization data on their panels of MME patients. <- *must identify means through which this will occur* 2) The ASOs will provide technical assistance to PCMH participating primary care practices that are HN members to enhance their capacity to provide timely, person-centered support to MME patients.

Member Services	Under Model 2, an MME's identified Lead Care Manager will act as his or her point of contact for all of the issues identified at left and will either 1) support the MME directly, e.g. with a referral to social services supports; and/or 2) liaise with the ASO call center in support of an MMEs need for information on benefits, referral to a specialist and/or registering a complaint or grievance. As is described in the Beneficiary Protections section, Connecticut will seek in partnership with CMS to implement a unified grievance and appeal process as between Medicare and Medicaid, to streamline and universalize the process for MMEs. *<- must expand this section to include all aspects addressed by Beneficiary Protections section of application*